Trust in the Doctor-Patient Relationship

A Senior Honors Thesis

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by

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I. Trust and Autonomy

Onora O'Neill notes in her book, *Autonomy and Trust in Bioethics,* that trust in the medical professions has been decreasing in recent years, even though "we might expect the increasing attention paid to individual rights and to autonomy to have increased public trust in the ways in which medicine is practiced and regulated."[1] Instead, "the loss of trust is a constant refrain in the claims of campaigning groups in the press."[2] She argues that this is dangerous insofar as the decline of trust in their doctors affects the ability of the patients to make autonomous decisions about their own health.

Although concern about the loss of trust is widely shared, there is disagreement about what type of trust is necessary to the doctor-patient relationship. Annette Baier's conception of trust as necessarily involving an element of good will on the part of the trusted party, has been influential in characterizing the medical relationship. On the other hand, Allen Buchanan contends that Baier's concept of trust is not necessary for the medical relationship; rather, he suggests that a form of mere reliance, implying nothing about good will on the part of the doctor, is sufficient for the well-functioning of the doctor-patient relationship, especially in the modern world of managed care organizations.[3] Recognizing that managed care organizations are replacing the traditional doctor-patient relationships as sources of medical care, Buchanan argues

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[1] O'Neill, O. *Autonomy and Trust in Bioethics (Gifford Lectures, 2001)*. Cambridge University Press, New York, 2002, 3.

[2] Ibid, 3.

[3] I apply his analysis not just to managed care organizations, but also to large hospitals and other large medical facilities where the doctor and patient do not necessarily have a meaningful, long-standing relationship.

the decline of Baier-style trust is of no concern, and that the type of trust he endorses can be maintained.

The aim of this paper is to examine Buchanan's claim about the type of trust required in the modern medical context, and whether that sort of trust can allay the worries of those who are concerned about the decline of trust in doctors. I will argue that a loss of Baier-style trust is of important concern, and that the worry stems from the inability of managed care organizations, and other large medical institutions, to supplement the Baier-style trust traditionally associated with the doctor-patient relationship.

I will begin by considering Baier's view regarding trust in a relationship. I will then turn to Edmund Pellegrino's notion of trust, and its requirements, in the medical context. Following Baier and Pellegrino, I will discuss Buchanan's view of reliance, specifically derivative merit trust. Finally, I will use the traditional models of the doctor-patient relationship to argue that Baier-style trust is important.

II. Trust, Reliance, and Goodwill

Baier's account of the concept of trust and what it requires in a relationship provides a good starting point for understanding the notion of trust. She argues that we must distinguish *trust* from another form of dependent relationship, *mere reliance*.[4]

It is clear that we depend on people everyday, whether it is a mailman or a friend. However, the type of dependence in each of the relationships seems to be different. Baier claims

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[4] Baier, A. Trust and Antitrust. *Ethics*, *96*(2), 1986, 235.

that we utilize the concept of reliance, and not trust, when we expect the mailman to perform his role and bring us our mail.

Reliance is the idea that I plan my actions in light of expectations that an individual will act in a certain way. I expect, for example, the librarian to shelve the books in the appropriate place. This expectation may be grounded in past experience, in my understanding of the role of the librarian, or in other considerations.

Mere reliance is sufficient for the proper functioning of certain kinds of relationship, and is justified under certain conditions. Consider the medical context. Certain institutional pressures and demands, including legal rules and organizational policies, regulate a doctor's actions; consequently, patients can rely on their doctors because the doctors have external incentives to act to help, and not hurt, the patient. The threat of punishment can motivate the doctors not to harm their patients, and rewards for good health outcomes can motivate them to provide quality care. To be justified, reliance simply requires some degree of certainty, on whatever grounds, that an individual, whether a mailman, a librarian, or a doctor, will perform and fulfill the expectations of the other depending on him.

Baier asserts, however, that personal relationships with friends, family members, and others whom we know personally, involves a different notion of dependence than mere reliance. She says that when I trust a friend, I not only rely on the friend, but also "depend on her good will toward" me.[5] As such, Baier suggests that when I trust those individuals in personal relationships, I am actually depending on their good will, or "at least the absence of grounds for expecting their ill will or indifference."[6] This concept requires, then, that I have *particular*

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[5] Ibid.
[6] Ibid.

grounds for my confidence that the individual whom I trust will not fail my expectations or otherwise take advantage of my dependence on her.

To further develop this conception of trust and to understand it more clearly in the medical context, I turn, in the next section, to the work of Edmund Pellegrino.

III. Trust in Medicine

Pellegrino has developed Baier's account of trust and applied it to professional relationships, such as the doctor-patient and the lawyer-client relationships. His understanding of professional relationships leads him to suggest several elements he believes are necessary for trust in such relationships. The first element is confidence, on the part of the trusting party, that "expectations of fidelity to what is entrusted will be fulfilled."[7] The first element constitutes the idea that the patient has confidence that she can depend on the doctor to deliver good care and treatment. This is the same as the element of *reliance*.

The second element in Pellegrino's analysis "is the sense that the person trusted has explicitly or implicitly made a promise to act well with respect to the interests of the person trusted."[8] Call this the element of *promising.* Pellegrino suggests that medical professionals make promises to act well towards their patients. This promise incorporates, in a strong way, the idea of good will or good intentions that Baier mentions in her thesis. The promise includes an understanding that the physician will take into account the patient's values before deciding on a course of action that is in the best interests of the patient. It is also possible that the promise

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[7] Pellegrino, E. Trust and Distrust in Professional Ethics. *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects*. Georgetown University Press, Washington D.C., 1991, 72.
[8] Ibid.

extends beyond just the doctor and the patient; there must be promises made to others, including family members and other professionals. The element of promising implies that, at the very least, the physician must try to act well towards her patient.

The third element is "the belief that discretionary latitude of certain proportions is necessary if trust is to be fulfilled and that the one trusted will use it well, neither assuming too much nor too little."[9] Pellegrino indentifies this element—the element of *discretionary latitude*—because he recognizes that medical diagnoses require interpretation of data that is often not conclusive. This requires an understanding in the relationship that the doctor must have a certain amount of freedom to interpret the data in order to suggest what he believes is the most appropriate diagnosis and treatment.

The fourth element in Pellegrino's account is that both the one trusting and the one trusted are equally aware of the first three elements and that each of them respects the above elements equally.[10] A firm and shared understanding of the first three elements results in a relationship in which each of the two parties knows what is expected of her, and how each party should proceed in the relationship. Call this the element of *common understanding*.

The fifth and final element is that "underlying of all of these elements [elements one through four] is an act of faith in the benevolence and good character of the one trusted."[11] This element of *benevolence* captures the main difference Baier noted between mere reliance and trust. Pellegrino agrees that the intentions of the doctor toward the patient matters for the account of trust. To trust the doctor, the patient must believe in his good intentions, and where such belief is not justified, then neither is trust.

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[9] Ibid.
[10] Ibid.
[11] Ibid.

This kind of account of trust has been influential, but we might ask whether the sort of justified dependence important to the doctor-patient relationship must include all of these elements, or even the key element of benevolence itself. Allen Buchanan has given reasons to think that in the modern medical context, the focus on doctor-patient trust as a robust relationship going beyond mere reliance is misguided.

IV. Derivative Merit Trust

Buchanan has argued that we ought to evaluate medical relationships by appeal to different forms of reliance, not the trust that involves a notion of goodwill. In particular, he argues that there is one type of reliance that sufficiently helps safeguard against harms that a doctor can do to the patient, and justifies patient dependence.

The key notions in Buchanan's "Trust in Managed Care Organizations" are what he terms "status trust" and "merit trust."[12] "Status trust" is the notion of trustworthiness attached to individual doctors, and teachers, because of the social group to which they belong. For example, Buchanan claims that, earlier in the century, individual doctors enjoyed extraordinary levels of status trust because the special group to which they belonged was socially revered. The central claim regarding status trust is that patients used to depend on their doctors, in large part, because their doctors belonged to a revered group, and not because the individual doctors provided any further reason to trust them.

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[12]Buchanan, A. Trust in Managed Care Organizations. *Kennedy Institute of Ethics Journal*, *10*(3), 2000, 189.

Buchanan claims that this status trust is eroding, and that merit trust is replacing status trust. Merit trust is trust in the expertise of doctors. This trust is not derived from societal trust, but from evidence of the doctors' abilities. Buchanan emphasizes that this type of dependence can be based on the patients' beliefs that every doctor in a medical institution is competent, and has passed certain criteria and proven that she is capable of treating patients.

Buchanan separates merit trust into *primary merit trust* and *derivative merit trust*.[13] Primary merit trust is the dependence on individual doctors, for individual reasons. It is founded upon the patient's belief that the doctor is capable, based on qualifications or past experience, as well as the belief that the doctor actually cares for the patient. Essentially, primary merit trust is the idea that the patient can believe in the doctor because of the individual doctor's credentials, certifications, reputation, and past actions known to the patient.

Derivative merit trust is based on the trust in the organization. Buchanan contends that we often depend on professionals because we depend on the organizations to which they belong. For example, I often depend on the works of reporters who write for the *New York Times.* I read their articles and presume that none of the information is fabricated. I depend on their work not because of their personal attributes or accomplishments, but because they write for the *New York Times*. In such a case, I depend on the organization, the *New York Times*, to regulate who can write for it. This contrasts with the primary merit trust I may have in a particular writer whose work I have followed carefully, and trust independent of his connection to a trusted news organization.

Buchanan argues that the same idea applies to managed care organizations. Often, we believe in a professional because the institution that hires the professional has certain regulations

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[13] Ibid, 194.

and is trustworthy. In the medical setting, Buchanan believes that patients will trust doctors because they trust organizations such as the American Medical Association, the hospitals that hire the doctors, and other institutions that legitimize the doctors' work. The institutions screen the trustworthy doctors, from those that are not, through strict requirements, accreditation, and professional standards.

Buchanan claims that there is a shift in medicine, from status trust to merit trust, particularly to derivative merit trust and that the shift is "on balance, a good thing."[14] His reason for this claim is that he believes that a shift to derivative merit trust will produce the best outcomes for the patients by allowing for a more dependable method of delivery of medical care. Ultimately, he states that his goal is to "develop a conception of well-founded merit trust, based on the conditions of managed care, rather than the picture of the physician-patient encounter that shapes traditional medical ethics."[15]

The important point here is that derivative merit trust is akin to Baier and Pellegrino's account of reliance. Baier and Pellegrino claim that reliance is the idea that an individual depends on another for certain outcomes; however, they suggest that reliance does not require the one being depended upon to have any good will or good intentions towards the other. Buchanan notes that the medical relationship is changing, especially towards the distribution of medical care through managed care organizations, not necessarily through individual doctors. He suggests that this is sufficient for the flow of quality medical care as long as the patient can depend on the organization that certifies doctors to practice in a certain place. Because the health outcomes produced will be those that we seek, Buchanan believes that derivative merit trust is a sufficient account of the type of dependence necessary in the medical setting.

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[14] Ibid, 191.
[15] Ibid, 195

V. Is Robust Trust Necessary?

Buchanan states in his article that erosion of robust trust might not be detrimental, overall, if it is accompanied by the increase in derivative merit trust. His argument turns crucially on his exclusive focus on health outcomes. Given that focus, what matters in the doctor-patient relationship is simply whether our mere reliance is justified.

Derivative merit trust in the managed care organization can help provide the safeguards necessary to prevent any malicious harm to the patient. The managed care organization, furthermore, actually encourages the best outcomes for the patient.

The question I will consider, then, is whether derivative merit trust captures all that is vital to the doctor-patient relationship. To do so, I will analyze several traditional models of the doctor-patient relationship, each originally developed without explicit attention to more recent issues around trust. Each of the traditional models tries to picture some important aspect of the doctor-patient relationship. By considering the models, I hope to see what sort of trust each one represents.

VI. A Brief Introduction To The Models

The first model that I will survey is the *technical model*. The technical model, also called the engineering model, was posited by Robert Veatch.[16] In this model, the doctor is a technician capable of diagnosing and carrying out a treatment for the patient. During the process, however, the doctor refrains from advocating a particular course of action that involves a decision beyond

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[16] Veatch, R. Models for Ethical medicine in a Revolutionary Age. *The Hastings Center Report*, *2*(3), 1972, 5.

the narrow technical considerations that constitute his expertise. His own value judgments, and his assessments of how to promote the patient's values, are outside the scope of his appropriate role. As such, the doctor simply carries out the treatment option the patient requests.

The second model for consideration is the *paternalistic model*. The paternalistic model, called the priestly model by Veatch, advocates a stance vastly different from the technical model.[17] Whereas the technical model suggests an independent doctor, the paternalistic model suggests a doctor that is heavily involved with the patient. In particular, the paternalistic model suggests that the doctor is heavily involved in the patient's care. According to this model, the physician behaves like a parent to the patient; the physician comprehends the patient values, and, using his judgment, offers a diagnosis, and suggests a course of treatment that is in the patient's best interests. One upshot of this model's main feature is that the patient's autonomy is often reduced.

The third model is the *contractual model*. The contractual model conceives of the doctor-patient relationship as involving a contract between the doctor and the patient.[18] The contract, furthermore, is neither explicit nor legalistic. That is, we must not conceive of the contract as a legal contract; rather, we must conceive of the contract as one that exists between two married individuals. Veatch believes that such 'contracts' between the individuals in a married couple offers a good understanding of the contractual model. Furthermore, Veatch considers the idea that these contracts, unlike legalistic contracts, are not explicit. Rather, they are implicit contracts to which individuals agree by performing certain acts, such as, in the case of the doctor, agreeing to treat the patient.

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[17] Ibid, 6.
[18] Ibid, 6.

The fourth and final model that I will consider is the *teacher-pupil model*.[19] The teacher-pupil model suggests that the doctor is the teacher, and the patient is the pupil. This model recognizes characteristics of the patient that few of the other models do. It recognizes the doctor as the holder of the information and the dispenser of the medical treatment. Another distinct characteristic of this relationship is the emphasis on the idea that the doctor *is* often a teacher to his patients. This model suggests that the doctor will be involved in the decision-making process, along with the patient. In this scenario a doctor would inform the patient, as a teacher does, about the technical information, and suggest a treatment for the patient. That is, after deliberating with the patient, the doctor recognizes the patient's health values and advocates a course of treatment that focuses on achieving those health values.

VII. Technical Model

The first model is the technical model. As mentioned above, the technical model represents the doctor as an expert technician and the patient as a recipient of technical information. Emanuel and Emanuel describe the model in the following way:

> "In this model, the objective of the physician-patient interaction is for the physician to provide the patient with all relevant information, for the patient to select the medical interventions he or she wants, and for the physician to execute the selected interventions."[20]

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[19] Ibid, 6.
[20] Emanuel, E., & Emanuel, L. Four Models of the Physician-Patient Relationship. *Journal of American Medical Association*, *267*(16), 1992, 2221.

Emanuel and Emanuel state that the technical model, or the "informative model," describes a relationship in which the physician informs the patient of the disease, the possible courses of treatment, and the risks and benefits associated with each of the treatments. The physician is knowledgeable, further, about the patient's personal values. According to this model, however, the physician does not advise the patient regarding which treatment to choose; instead, she merely informs the patient about the choices available.

The role of the patient is to decide a course of action for the treatment based on his own personal values. The patient integrates the information presented by the doctor and makes a decision considering his own values, and the risks and benefits of certain treatments. According to the technical model, the physician does not have an active role in deciding between the various courses of treatment.

The technical model seems to require only that the technical information about diseases, symptoms, and methods of intervention provided by the doctor be reliable. It is not immediately clear that any further sort of dependence or trust is pictured by this model. The technical model focuses on the ability of the doctor to apply the knowledge that she has accumulated through education and experience. In focusing on purely the application of knowledge, the model advocates a detached doctor who does not use the patient's values when considering treatments that would most benefit the patient. The doctor remains detached because she does not consider the patient's values; instead, she is concerned only with the medical outcomes for the patient.

The doctor knows the medical information necessary for diagnosis and treatment. Because the doctor knows the information, we depend on her to convey accurate information, especially about the disease, the interventions, and the risks and benefits associated with the

interventions. This raises an important concern about how to ensure that the doctor will use the information to help, and not harm, the patient.

One type of safeguard we could consider involves the robust notion of trust suggested by Pellegrino. But it is doubtful that all five elements are described by the technical model. On his view, for instance, the physician must make a promise to his patient that he will act in the best interests of his patient. Further, the implicit, or explicit, promise must suggest that the patient will receive not only accurate information, but also suggestions that would take into account the patient's values. However, the technical model does not suggest that the physician makes any such promise. In fact, the model represents the doctor and the patient as being disengaged, without an implicit or explicit promise. This disengagement impacts how the physician incorporates, or does not incorporate, the patient's values into his presentation of the pertinent information. Because of this disengagement, it is not possible that this model describes the type of dependence, namely robust trust, suggested by Pellegrino.

Let us consider Buchanan's derivative merit trust. If the doctor is working in a managed care organization, the doctor can perform the necessary technical aspects of his work without having to promise, implicitly or explicitly, to take into account the patient's values when considering the possible treatment plans. However, there might be promises made to her superiors, or to the institution for which she is working. For example, the doctor might sign a legal contract suggesting that he will present only accurate information to the patient and make the diagnosis based on appropriate information. This contract allows for the existence of the safeguard, but implies nothing about the doctor's good will toward the patient herself. The doctor is legally responsible for presenting the most accurate information to the patient because of the fear of punishment by the institution with which she works. This forms the core of derivative

merit trust. The patient is able to rely on the doctor because the institution prevents the physician from harming the patient.

Ultimately, the technical model describes only the doctor's knowledge of medical facts and issues. It does not consider other aspects of the doctor-patient relationship, such as communication, interaction, and deliberation, which often takes place between a physician and her patient. By describing the physician as being detached from her patient, the technical model describes a relationship that requires only derivative merit trust to ensure the patient's safety.

We might worry, however, that the technical model, even if it captures something of importance in the doctor-patient relationship, seems to describe only a small aspect of the doctor-patient relationship. It does not consider the possibility of any interaction in the doctor-patient relationship beyond the requirement of the doctor to inform the patient about the possible options for treatments. This limited view is inaccurate, however, because of several important elements of the doctor-patient relationship, such as assistance in choosing a certain treatment and the doctor's involvement in the decision-making process. Veatch raises an important concern regarding the technical model's description of the doctor-patient relationship when he writes, "Choices must be made daily […] and each of these choices requires a frame of values on which it is based. Even more so in an applied science like medicine choices based upon what is "significant," what is "valuable," must be made constantly."[21] He contends that it is not possible to make judgments in life without considering values, whether the values are the physician's values or the patient's values. He argues that the technical model is therefore inaccurate in describing the doctor-patient relationship because it does not account for the values.[22] This suggests that the technical model does not describe the doctor-patient relationship fully. In fact,

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[21] Veatch, 5.
[22] Ibid.

as we proceed through other models that picture more than the information-providing role of the doctor, we will notice that derivative merit trust begins to look insufficient as an account of the sort of dependence necessary to a well-functioning doctor-patient relationship.

VIII. Paternalistic Model

The most important characteristic of the paternalistic model, which makes it unique in comparison with all of the other models, is the nature of the doctor's involvement in the patient's well-being and health:

> In this model, the physician-patient interaction ensures that patients receive the interventions that best promote their health and well-being. To this end, physicians use their skills to determine the patient's medical condition and his or her stage in the disease and process to identify the medical tests and treatments most likely to restore the patient's health or ameliorate pain.[23]

Emanuel and Emanuel claim that the physician is involved in the lives of the patients, to the extent of presenting "the patient with selected information that will encourage the patient to consent to the intervention the physician considers best."[24] This suggests that the physician limits the patient's autonomy to make informed decisions about the status of her health and the treatment that suits her needs. Emanuel and Emanuel suggest that the limitations on autonomy can vary widely. On the account that allows the patient to make decisions, the doctor strongly suggests one type of treatment over another. At the very extreme, the paternalistic model implies

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[23] Emanuel, E., & Emanuel, L., 2221.
[24] Ibid.

that the "physician authoritatively informs the patient when the intervention will be initiated."[25] In this instance the doctor has the decision-making authority regarding the treatment of the patient's ailment. The doctor's ability to make these judgments about the patient's well being is derived from knowledge about the patient's best interests.

According to the paternalistic model, the patient's autonomy and decision-making authority is vastly diminished because of the physician's extensive involvement in the patient's treatment. The patient's limited autonomy could potentially result in the patient's harm; however, as long as there is either trust or reliance in the relationship, the patient does not need to worry about possible harm.

The patient does not necessarily need a great amount of autonomy in the relationship: if the doctor knows the patient's medical, family, and social histories, the doctor can suggest treatment that would be in the best interests of the patient. In such a case, the patient does not need to make a decision regarding his medical care.

I want to now return to the problem posed earlier. There must be some safeguard to prevent harm to the patient. The patient must be able to depend on the physician because the physician makes extensive decisions about the patient's health and life. Reliance, or derivative merit trust, is one way to prevent such harm.

Buchanan might not agree that the paternalistic model offers the best representation of the doctor-patient relationship; even still, Buchanan could maintain that derivative merit trust would be sufficient for effective treatment and prevention of any harm to the patient. The patient need not worry about any potential harm because of institutional provisions. For example, the doctor could be involved heavily in the patient's life and have extensive influence over the

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[25] Ibid.

patient's medical decision. This excessive influence would not be problematic because the institution would prevent the physician from harming his patient. As such, Buchanan could argue that derivative merit trust is sufficient for the relationship to function well.

Buchanan could essentially argue that there is no need for trust by suggesting that there are safeguards that would prevent a paternalistic doctor from harming his patients. But this does not capture the important aspects of the paternalistic model as a representation of (part of) the doctor-patient relationship. The paternalistic model defines the relationship as a personal one. Such a personal relationship involves more than institutional safeguards.

This model describes the relationship as being akin to the relationship between a parent and a child. A parent is responsible for the child's safety, health, and success. Furthermore, by having children, and thereby accepting the role of the parent, the parent agrees to treat the child in a certain manner. That is, the parent agrees to consider the child's best interests in making decisions that impact the child. In such a familial relationship, there seems to be more than derivative merit trust. Instead, there must be trust and a notion of goodwill.

The paternalistic model recognizes similar elements in the doctor-patient relationship. The model describes the patient as a child, and the doctor as a parent. The model suggests that the physician accepts certain responsibilities by agreeing to care for the patient. The physician, like a parent, takes the responsibility of the patient's welfare. Particularly, the physician agrees to consider the patient's values and suggest certain treatments that accord with the patient's values.

In a parent-child relationship, the parent makes an implicit promise to the child, saying that he will take care of the child. It is true that, most often, a parent does not make an explicit promise to take care of his child and to ensure that he will act to benefit the child. However, we may consider certain instances as instances when a parent makes an implicit promise. We might

consider the parent having a child and properly raising the child as an instance of making an implicit promise to the child. The implicit promise, further, would be that the parent would do that which is in the best interests of the child.

The physician, like a parent, has extensive decision-making authority, and the patient, like a child, depends on the physician to help him make medical decisions. The physician diagnoses the patient and, after considering the patient's values, offers a suggestion that would best serve the patient's interests.

In agreeing to help the patient, the physician makes an implicit promise to the patient. The physician promises to consider the patient's values, and, based on the values, act in the patient's best interests. This element of promising changes the notion of trust in the paternalistic model from mere reliance, as suggested by Buchanan, to a notion of trust. The doctor's pledge to help the patient and to consider the patient's best interests in making medical decisions describes a relationship in which the patient trusts the doctor, and does not merely rely on the doctor.

Another consideration regarding this model describes trust and not mere reliance. Of course, patients are not to be treated like children (and so the paternalistic model has its own shortcomings in failing to represent the value of patient autonomy), but like a parent, the physician is a caregiver to the patient. The model describes the physician as a parent to indicate that the physician cares about the patient's well being and is genuinely interested in making the patient healthy. The physician's care for the patient, as described by the paternalistic model, describes a notion of benevolence on the part of the physician. This element also indicates that the notion of dependence in the doctor-patient relationship, according to the paternalistic model, is trust, not mere reliance.

IX. Contractual Model

The contractual model recognizes some of the important social conventions that exist in our society. Veatch claims that the contractual model must be thought of not as a contract in a legalistic sense, but rather of a traditional marriage "contract" or covenant. These contracts require two individuals to share the responsibilities. The contracts also have terms that both parties must agree to uphold. For example, in a marriage, the spouses agree to not become intimately involved with anyone else but the spouse to whom they are married and, more importantly, to consider the other party's best interests when making decisions. Similarly, in a doctor-patient relationship, both the doctor and the patient have certain responsibilities that they agree to uphold. The doctor agrees to take care of the patient, and the patient agrees to comply with the doctor's treatment plan.

Chalmers Clark recognizes that trust is necessary for the proper functioning of the contractual model; however, he does not specifically recognize the type of trust represented by the model.[26] To best understand the type of trust, we must first recognize the type of contract the relationship represents. As mentioned above, Veatch believes that we must consider the relationship to be similar to a marriage or a traditional religious covenant; however, we must consider the relationship to be devoid of any religious undertones.

Before we contemplate what type of dependence the model is advocating, we should recognize why Veatch believes that the relationship is similar to that of a traditional contract between two married individuals. A marriage requires two individuals to agree to be married and to make an explicit promise not to become involved intimately with others to whom they are not

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[26] Clark, C. Trust in Medicine. *Journal of Medicine and Philosophy*, *27*(1), 2002, 13.

married. This is in consideration of the best interests of the spouse with whom one is involved. That is, the person promising to marry suggests that he will not become intimately involved with someone else because he realizes that it is not in the interests of the person to whom he is getting married. Therefore, the promise to not become intimately involved with someone else is rooted in the consideration of the values and the best interests of the person whom she is marrying.

Let us now consider the type of dependence described by this model. Let us consider the possibility of derivative merit trust, or some other form of reliance. Derivative merit trust requires us to be capable of trusting the institution that allows the doctor to act in a certain way. It seems that, at the very least, the model describes this notion of reliance. All doctors operate within the limits of the law and the limits of the institutions to which they belong. Within these limits, the doctors must provide certain services without harming the patient in order to avoid being punished. While the account of derivative merit trust seems to be accurate, it seems to provide an incomplete picture of the contractual model.

Veatch implies that a marriage contract does have self-interested terms; that is, both parties agree to act in a certain way based on their self-interests. This alone would be sufficient to describe derivative merit trust. However, this cannot be an accurate description of a marriage contract. In order for a marriage contract to exist, both parties promise to consider the best interests of the other. In much the same way, the doctor and the patient have self-interests, which they seek to act upon when they enter into a relationship; however, this model describes the doctor as having the best interests of the patient in mind when he is suggesting the diagnosis and treatment. The doctor promises, therefore, to consider the patient's values and to act in the best interests of the patient. Thus, the element of promising indicates that the contractual model

describes trust, and not mere reliance, as being important to the well-functioning of the relationship.

X. Teacher-Pupil Model

The teacher-pupil model, termed the deliberative model by Emanuel and Emanuel, is focused on the deliberation between the patient and the physician. Emanuel and Emanuel state the following:

> The aim of the physician-patient interaction is to help the patient determine and chose the best health-related values that can be realized in the clinical situation. To this end, the physician must delineate information on the patient's clinical situation and then help elucidate the types of values embodied in the available options.[27]

Emanuel and Emanuel emphasize that the teacher-pupil model, like the paternalistic model, focuses on health-related values. An important similarity between the paternalistic model, the teacher-pupil model, and the contractual model is that according to all three of the models the physician, considering the patient's health-related values and best interests, suggests a course of action. A distinct characteristic of the teacher-pupil model is that both the physician and the patient engage in dialogue about the medical action that would be best for the patient.[28]

The teacher-pupil model is similar to the paternalistic model in that there is doctor input into the patient's care. Whereas the paternalistic model describes the doctor as the individual making the decision about the patient's care, the teacher-pupil model suggests that decisions about care arise from the patient himself. The decisions, according to the teacher-pupil model,

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[27] Emanuel, E., & Emanuel, L., 2222.
[28] Ibid.

are made in a unique manner. Unlike the paternalistic model, the teacher-pupil model involves discussion and deliberation about the patient's health-values and condition. This deliberation leads to the patient's decision about the course of treatment. The teacher-pupil model is different from the technical model as well. The technical model illustrates the doctor-patient relationship as being one in which the doctor would only relay the information, but not suggest any course of treatment that is based on the patient's values. Contrary to the technical model, the teacher-pupil model suggests that the doctor shares the technical information with the patient, and, considering the health-values, discusses with the patient the most appropriate treatment.

Interestingly, the teacher-pupil model indicates that, at times, the doctor must *actually* be a teacher to the patient.[29] The doctor often assumes the role of a teacher in the relationship. For example, when the doctor prescribes the medication, he is in charge of describing the action of the drugs, and how they will affect the patient's health. Another example is of a doctor suggesting that the patient refrain from acting in ways detrimental to the patient's health. In both cases, the doctor, an instructor, educates the patient, a student, on what medications to take and what behaviors to engage in.

The description that May offers results in a better understanding of the teacher-pupil model. When we commonly think of a teacher, we recognize that the teacher is technically adept and presents information accurately, and ensures that the student learns the material. Similarly, the doctor is technically adept and presents information that is often prescriptive. Furthermore, the doctor deliberates with the patient and prescribes a course of action that takes into account the patient's values.

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[29] May, W. F. *The Physician's Covenant: Images of the Healer in Medical Ethics* (2 ed.). Louisville: Westminster John Knox Press, 2000.

Of course, teachers have the potential to deliberately deceive and misguide their students. However, most teachers, if not all, refrain from doing so. Clearly, there are institutional regulations that prevent teachers from misusing their power and deliberately misguiding the pupils. Moreover, these regulations alone could engender in the pupils the confidence to depend on their teachers to present accurate information. In much the same way, patients can have confidence in their doctors because of rules and regulations. In such a case, we have the description of derivative merit trust, as suggested by Buchanan.

The description of the teacher's role seems to be incomplete however. As such, there must be more than mere reliance in the teacher-pupil relationship. A teacher's role is not only to educate her students, but also to encourage and nurture her students as they progress through the learning process. Implicitly, there seems to be a promise made by a teacher to her students—the teacher promises her students that she will teach them to the best of her ability. Therefore, the teacher makes a promise to act in the best interests of the students so that the students can become knowledgeable and educated. The notion of trust best accounts for the teacher's promise to her students to inform them and not misguide them intentionally.

According to the teacher-pupil model, the doctor is like a teacher in that she promises to offer information and care for her patient. She also promises not to deliberately misguide her patients. This promise is similar to that of the teacher's promise not to deceive her pupils and offer them, purposefully, wrong information. Therefore, this model describes a particular notion of trust. While derivative merit trust seems to be sufficient to prevent harm to the students, and the patients, the teacher makes a promise to educate and inform her students. This promise indicates that the model requires trust to function properly.

XI. Reasons for Trust over Mere Reliance

Buchanan argues that derivative merit trust is sufficient, and that a robust notion of trust is not required, to explain the well-functioning the doctor-patient relationship. Our consideration of the models gives us reason to reject his claim.

Buchanan argues for derivative merit trust because he recognizes that the nature of the physician-patient relationship is changing. Buchanan asserts that the relationship is not as personal because doctors are hired, increasingly, by managed care organizations. Because the doctors work for organizations, they have varying schedules and do not create long-standing rapports with patients that eventually transform into personal relationships. Buchanan is correct in suggesting that the relationship is changing. He is also correct in suggesting that the lack of a relationship precludes, in many instances at least, the formation of robust trust. Buchanan notices that there might not be trust of any sort and that a lack of trust increases the risk of danger of the physician harming the patient. His response to this increasing worry about patient care and patient safety is derivative merit trust. He accepts that there has been a decline of robust trust, but argues that managed care organizations ensure patient safety and good health outcomes through regulations and board certifications.

For Buchanan, it would seem that as long as the outcomes are favorable, there is no need to be concerned about the loss of trust. However, a review of the four models above shows that Buchanan has a limited view of the important elements of the doctor-patient relationship. Except for the technical model, the traditional doctor-patient models – each of which, though incomplete, captures something of significance – seemed to require more than mere reliance for

their well-functioning. The models show that robust trust is an important element of the doctor-patient relationship, which, if lost, would represent a significant moral loss.

I recognize that the robust notion of trust required by some of the models might be far more idealistic than what might be implementable in the real world. Certainly, the modern medical context, with large hospitals and large managed care organizations, makes it difficult for a rapport to start between a doctor and his patient. Furthermore, it seems that the kind of relationship advocated by the models seems difficult to attain in a real-world setting.

It seems that the difficulty of achieving such an idealistic form of the doctor-patient relationship leaves us with a difficult choice. If we do not accept the type of relationship suggested by the models, it seems that our only option is to accept Buchanan. Let us consider what may result, if we do accept a picture of the doctor-patient relationship to be something of the type that Buchanan suggests.

Consider a picture that seems like something Buchanan might accept. It seems like derivative merit trust would allow doctors to not care for the patient for the patient's sake. Derivative merit trust, as such, might allow doctors to act out of self-interested terms: the doctor might not do any harm to the patient not because she cares for the patient, for the patient's own sake, but because she seeks to avoid penalties. At the extreme, this seems to be a picture that Buchanan might accept. But, our common beliefs and our common understanding seem to suggest that we care about more than just the outcomes in medical situations. It seems that, at the very least, we want doctors who care for us, for our own sakes. This element of care, furthermore, seems to be the element that Baier sites—the element of good will. If it is the case that we want doctor who cares for us, then, it seems as though we want a relationship that is more involved than Buchanan's picture seems to suggest.

Even if we remain focused on outcomes, there is reason to worry about the exclusive focus on derivative merit trust. Consider again the element of discretionary latitude. By discretionary latitude, Pellegrino means the liberty of medical professionals to judge the information, and inform the patient of the appropriate diagnosis of the ailment, and possible courses of treatment. The need for this liberty arises from the nature of the profession. Often times, the data from the techniques is not conclusive, and therefore, requires the doctor to make certain judgments regarding the diagnoses, procedures, etc. The problem with this latitude, however, is that it could potentially allow the doctors to abuse their liberties and harm their patients.

Buchanan would argue that, in fact, derivative merit trust could in principle be justified in all cases through the use of organizational procedures. However, this seems unlikely. There is no way to regulate away all discretion and opportunity for abuse through institutional incentives and protocols.

Let us suppose that managed care organizations institute more regulations, as Buchanan might suggest. I would argue that the increased regulations would still be insufficient. Organizational regulations will not be sufficient because doctors, regardless of how much regulation exists, will still require discretionary latitude to be able to properly judge the symptoms and arrive at a diagnosis. Because doctors need this freedom to judge the symptoms, derivative merit trust will never be sufficient. Consider Pellegrino's discussion of the importance of discretionary latitude in the case of living wills, particularly those that concern decisions about palliative care.[30] A living will is supposed to make explicit the wishes of the dying patient. A living will can be limited, however, because it cannot make recommendations for every situation.

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[30] Pellegrino, E., 75.

That is, a living will cannot possibly suggest a course of action for the myriad problems that could potentially occur. Therefore, the person in charge of the patient's care must have the latitude to suggest the course of action that would be best for the patient. This latitude, further, gives the doctors freedom to benefit or harm the patients. In cases such as these, derivative merit trust would be insufficient, and relying on derivative merit trust would not offer the safeguards, as Buchanan believes.

We recognize that the need for discretionary latitude makes derivative merit trust insufficient in the doctor-patient relationship, especially in cases dealing with living wills. This insufficiency of derivative merit trust, therefore, necessitates robust trust. The patient must have confidence not only in the doctor's technical abilities, but also in the doctor's good intentions to help the patient and act in the patient's best interest.

Regardless of the health outcomes, there seems to be something valuable in relationships that involve promises. I will not pursue this issue here, but it does not seem as though we can remove the element of promising, or more generally good will, from the doctor-patient relationship without contributing to the rise of more impersonal, unconnected society.[31]

Buchanan suggests that a loss of this type is insignificant, especially in cases in which the outcomes can be regulated by relying on derivative merit trust. I contend, however, that a decline in robust trust represents a significant moral loss.

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[31] The decline of social trust has been a major theme of political theory since the appearance of Robert Putnam's "Bowling Alone." Here, I want to raise a related worry.

XII. Conclusion

There is reason to believe that moving to managed care organizations, and other large medical settings will, in fact, be detrimental, in important ways, to the doctor-patient relationship. Several traditional models provide evidence that mere reliance or derivative merit trust cannot provide all that has been expected from the relationship. Moreover, simply in terms of health outcomes, the institutions, which supply the derivative merit trust, cannot guarantee patient safety wherever discretionary latitude is required. Finally, the decline of robust trust, whatever the health outcomes, is something to be lamented insofar as it relates more generally to human interconnectedness.

References

Baier, A. (1986). Trust and Antitrust. *Ethics*, *96*(2), 231-260. Retrieved January 21, 2010, from the JSTOR database.

Beauchamp, T. L., & Childress, J. F. (2008). *Principles of Biomedical Ethics* (6 ed.). New York: Oxford University Press, USA.

Buchanan, A. (200). Trust in Managed Care Organizations. *Kennedy Institute of Ethics Journal*, *10*(3), 189-212.

Clark, C. (2002). Trust in Medicine. *Journal of Medicine and Philosophy*, *27*(1), 11-29.

Emanuel, E., & Emanuel, L. (1992). Four Models of the Physician-Patient Relationship. *Journal of American Medical Association*, *267*(16), 2221-2226.

Hall, M., Dugan, E., Zheng, B., & Mishra, A. (2001). Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?. *The Milbank Quarterly*, *79*(4), 613-639.

Hall, T. (2003). Bargaining With Hippocrates: Managed Care and The Doctor-Patient Relationship. *South Carolina Law Review*, *54*(689), 690-740.

May, W. F. (2000). *The Physician's Covenant: Images of the Healer in Medical Ethics* (2 ed.). Louisville: Westminster John Knox Press.

O'Neill, O. (2002). *Autonomy and Trust in Bioethics (Gifford Lectures, 2001)*. New York: Cambridge University Press.

Pellegrino, E. (1991). Trust and Distrust in Professional Ethics. *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects* (pp. 69-85). Washington D.C.: Georgetown University Press.

Putnam, R. (1995). Bowling Alone: America's Declining Social Capital . *Journal of Democracy*, *6*(1), 65-78.

Veatch, R. (1972). Models for Ethical medicine in a Revolutionary Age. *The Hastings Center Report*, *2*(3), 5-7. Retrieved November 23, 2009, from http://www.jstor.org/stable/3560825